Commonwealth of Massachusetts
Group Insurance Commission
P.O. Box 8747 • BOSTON, MA 02114-8747
(617) 727-2310 www.mass.gov/gic

Dental and Vision Enrollment and Change Form (FORM -1)

FOR MANAGERS, CONFIDENTIAL EMPLOYEES, THE LEGISLATURE, CERTAIN MBTA, CONSTITUTIONAL OFFICES AND THEIR STAFF ONLY. EMPLOYEES SUBJECT TO COLLECTIVE BARGAINING AND EMPLOYEES IN HIGHER EDUCATION, THE JUDICIAL COURT SYSTEM, MUNICIPALITIES AND AUTHORITIES ARE NOT ELIGIBLE.

PLEASE PRINT CLEARLY

01 ☐

Insured's GIC-ID (usually Soc. Sec. #)	Sex: Male ☐ Female ☐	Date of Birth / /	Dept. ID # or Agency/Division # /
Name - Last	First	MI	
Address: (Number and Street) This is a new Address ☐			
City	State	Zip Code	Employee ID (HR/CMS agencies only)
Date Entered Service: / /	Home Phone: ( )	Work Phone: ( )	

02 **NEW ENROLLMENT** ☐ **PROMOTION** ☐ **CHANGE** ☐ **CANCEL COVERAGE** ☐

EFFECTIVE DATE / /

Type of Coverage

Individual ☐ Family ☐

Dental Benefit (Please check One)

☐ Indemnity Plan (Classic)
☐ PPO Plan (Value)

I understand that I may not change this plan type until the next annual enrollment period.

Vision Benefit (Select Provider at Time of Service)

SPOUSE/DEPENDENT INFORMATION

CHECK ONE: ☐ **NEW MEMBER** ☐ **ADDITION** ☐ **DELETION** ☐ **CORRECTION**

List below all family members, including your spouse, who will be covered under your dental and vision family plan. Attach a separate sheet if additional space is required. Please provide all Social Security Numbers (required under Federal Law Section 111) and exact dates of birth for each dependent. To add a dependent age 19 to 26, you must complete and return to the GIC a Dependent Ages 19 to 26 Enrollment Form. **Important:** The Group Insurance Commission requires you to provide a copy of a marriage certificate, birth certificate, certificate of appointment as legal guardian, etc., for each person you list as a dependent.

Last Name	First	M.I.	Relationship	Date of Birth	Sex	Social Security Number (Required)

Reason for addition or deletion: _____ Effective Date: _____

03 ☐ **Name Change** Previous Name: New Name:

LEAVE OF ABSENCE

GIC USE ONLY: **Effective Date:** _____/01/_____ Leave Pay Status: ☐ Part ☐ Full

04 ☐ **Leave Is:** ☐ With Pay ☐ Without Pay

Leave Type (You MUST Check one of the following):

☐ Educational ☐ Family (for dep < age 3) ☐ Maternity* ☐ Personal Illness* ☐ Sabbatical ☐ FMLA
☐ Family (for dep > age 3) ☐ Industrial Accident* ☐ Military ☐ Personal Reason ☐ Suspension ☐ Other

*Industrial Accident (without pay), Maternity (without pay), and Personal Illness (without pay) leaves all require the employee to submit a Form 11 to the Group Insurance Commission with a letter from the agency head approving the leave of absence.

Duration of Leave: Start Date: ___/___/___ End Date: ___/___/___ Last Day on Payroll: ___/___/___

05 **Return to Payroll Deduction**: First Day Back in Payroll: / /

INSURED CHANGES

06 ☐	**Retirement**	Date Retired / /	
07 ☐	**Transfer to another Agency**	Name of Agency Transferred to	Effective Date / /
08 ☐	**Transfer from another Agency**	Previous Agency	Effective Date / /
09 ☐	**Termination Coverage** (if elected)	Termination Reason	Termination Date ___/___/___

☐ COBRA (must complete COBRA Dental application)

PLEASE READ CAREFULLY

Eligibility: I understand that the GIC determines eligibility for this program and the effective date of coverage. If I sign up for coverage and decide to cancel, or if my coverage terminates for non-payment of premium, the earliest I can re-join the plan is during the Annual Enrollment following two years.

Deduction Authorization: I authorize my employer to deduct from my payroll check the amount required for the dental and vision coverage I have selected.

Dental Plan: I understand that when I choose a dental plan, I cannot change plans until the next annual enrollment, even if my dentist leaves the plan.

x _____ _____ x _____ _____

Signature of Applicant Date Signature of Authorized Official Date

FOR GIC USE ONLY	ENTERED	VERIFIED	POLITICAL SUBDIVISION